

# ATTACHMENT 7

Sample CMS 1500 claim form for outpatient mental health and substance abuse services in the home or community — "biller only" providers

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

PICA										HEALTH INSURANCE CLAIM FORM										PICA																			
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Im A.</b>										3. PATIENT'S BIRTH DATE MM DD YY <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow St</b>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																			
CITY <b>Anytown</b>										STATE <b>WI</b>										CITY																			
ZIP CODE <b>55555</b>										TELEPHONE (Include Area Code) <b>(xxx) xxx-xxxx</b>										ZIP CODE																			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI-P</b>										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. EMPLOYER'S NAME OR SCHOOL NAME																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										c. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																			
c. EMPLOYER'S NAME OR SCHOOL NAME										10d. RESERVED FOR LOCAL USE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										SIGNED																			
14. DATE OF CURRENT: MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>I.M. Referring/Prescribing</b>										17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>12345678</b>										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>L290</b>										23. PRIOR AUTHORIZATION NUMBER																													
24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY										B Place of Service										C Type of Service																			
D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E DIAGNOSIS CODE										F \$ CHARGES																			
G DAYS OR UNITS										H EPSDT Family Plan										I EMG																			
J COB										K RESERVED FOR LOCAL USE																													
1 <b>12 02 03</b>										<b>12</b>										<b>90801 UA UC</b>										<b>1</b>									
2 <b>12 15 03</b>										<b>12</b>										<b>90806 UA UC</b>										<b>1</b>									
3 <b>12 22 03 29</b>										<b>12</b>										<b>90857 HO UC</b>										<b>1</b>									
4																																							
5																																							
6																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN										26. PATIENT'S ACCOUNT NO. <b>1234JED</b>										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ <b>XXX XX</b>									
29. AMOUNT PAID \$ <b>XX XX</b>										30. BALANCE DUE \$ <b>XX XX</b>										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <b>I.M. Provider</b> MM/DD/YY										32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)									
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Billing</b> <b>1 W. Williams</b> <b>Anytown, WI 55555</b> <b>87654321</b>																																							

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)